Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Rural Health Clinic

Billing Instructions

July 2001

About this publications

This publication supersedes all previous MAA Rural Health Billing Instructions.

Published by the Medical Assistance Administration
Washington State Department of Social and Health Services
July 2001

Received too many billing instructions?
Too few?
Address incorrect?

Please detach, fill out, and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

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Important Contacts

A provider may contact MAA with questions regarding its programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs.
[WAC 388-502-0020(2)]

Where do I call for information on becoming a DSHS provider, submitting a change of address or ownership, or to ask questions about the status of a provider application?

Call the toll-free line:
(866) 545-0544

Where do I send my claims?

Hard Copy Claims:
Division of Program Support
PO Box 9245
Olympia WA 98507-9245

Magnetic Tapes/Floppy Disks:
Division of Program Support
Claims Control
PO Box 45560
Olympia, WA 98504-5560

Electronic billing?
Electronic Billing Unit
PO Box 45512
Olympia, WA 98504-5512
(360) 725-1267

Who do I contact if I have questions on…

Policy, payments, denials, or general questions regarding claims processing, Healthy Options?

Provider Relations Unit
(800) 562-6188

Private insurance or third party liability, other than Healthy Options?

Division of Client Support
Coordination of Benefits Section
PO Box 45565
Olympia, WA 98504-5565
(800) 562-6136

Access Issues, Broker Transportation, Client Complaints, Healthy Options Enrollment, Disenrollment, Exemptions?

Medical Assistance Customer Service Center (MACSC)
(800) 562-3022 **Clients Only**

How can I get copies of billing instructions or numbered memoranda?

Check out our web site
http://maa.dshs.wa.gov, go to the Billing Instructions link.
Or write/call:
Provider Relations Unit
PO Box 45562
Olympia, WA 98504-5562
(800) 562-6188

Definitions

The section defines terms and acronyms used in this booklet.

Accept Assignment – When a medical provider agrees to accept Medicare payment for a given service or equipment as payment in full, except for specific deductible and coinsurance amounts for which the client is responsible.

Client - An applicant for, or recipient of, DSHS medical care programs.

Code of Federal Regulations (CFR) - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Core Provider Agreement - The basic contract that MAA holds with providers serving MAA clients. The provider agreement outlines and defines terms of participation in Medical Assistance.

Current Procedural Terminology (CPT) – A description of medical procedures available from the American Medical Association of Chicago, Illinois.

Department - The state Department of Social and Health Services [DSHS]. [WAC 388-500-0005]

Encounter Rate – An all-inclusive rate established by Medicare.

Encounter Code – A unique code assigned by MAA that allows a provider to bill for services.

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) – A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Healthy Options - The name of the Washington State Medical Assistance Administration's managed care program.

Internal Control Number (ICN) – A 17-digit claim number that appears on the MAA Remittance and Status Report near the client's name. This number is used as means of identifying the claim.

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. [WAC 388-538-050]

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI Children's Health Insurance Program (CHIP), and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Assistance IDentification (MAID) card – MAID cards are the forms DSHS uses to identify clients of medical programs. MAID cards are good only for the dates printed on them. Clients will receive a MAID card in the mail each month they are eligible. These cards are also known as DSHS Medical ID cards or medical coupons.

Medically Necessary - A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. [WAC 388-500-0005]

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each MAA client consisting of:

- First and middle initials (a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Primary Care Case Management (PCCM) The health care management activities of a provider that contracts with the department to provide primary health care services and to arrange and coordinate other preventive, specialty, and ancillary health services [WAC 388-538-050].

Program Support, Division of (DPS) – The division within MAA responsible for providing administrative services for the following:

- Claims Processing;
- Family Planning Services;
- Administrative Match Services to Schools and Health Departments;
- Managed Care Contracts;
- Provider Enrollment/Relations; and
- Regulatory Improvement.

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement [Core Provider Agreement] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. [WAC 388-500-0005]

Provider Number – A seven-digit identification number issued to service providers who have signed the appropriate contract(s) with MAA.

Remittance And Status Report (RA) - A report produced by MAA's claims processing system (known as the Medicaid Management Information System or MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

Rural Area – An area that is not delineated as an urbanized area by the Bureau of the Census.

Rural Health Clinic (RHC) – A clinic that is located in a rural area designed as a *shortage area* (CFR 42, Chapter IV, 491.2). A rural health clinic will be certified for participation in Medicare in accordance with subpart S of 42 CFR, part 405 (CFR IV, 491.3) as a hospital-based or freestanding facility.

Shortage Area – A defined geographic area designated by the Department of Health as having either a shortage of personal health services [under Section 1302(7) of the Public Health Service Act] or a shortage of primary medical care manpower [under Section 332 of that act].

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client. [WAC 388-500-0005]

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.
[WAC 388-500-0005]

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

Rural Health Clinics

What is a Rural Health Clinic?

A rural health clinic (RHC) is either a hospital-based or freestanding facility certified under Code of Federal Regulations (CFR), title 42, part 491. A rural health clinic is located in a rural area designated as a shortage area.

Those interested in applying for either one of the two types of RHCs should contact Medicare for criteria and qualifications.

How does MAA reimburse for services in a rural health clinic?

Encounter Code: Each RHC has a unique encounter code issued by MAA upon enrollment as a Rural Health provider. You must use your unique encounter code when billing MAA. If you do not know what your unique encounter code is, please call 1-800-562-6188. All services must be billed to MAA on a HCFA-1500 claim form.

Encounter Rate: MAA pays only for primary care services provided by Medicare-certified RHCs on an **encounter rate** basis, rather than on a fee-for-service basis. The encounter rate for each rural health clinic is established by Medicare and is for primary care services only. **Refer to Medicare's Rural Health Clinic Guide for covered RHC services.**

Note: Both hospital-based and freestanding RHCs must bill MAA for RHC-covered services using only their unique encounter code and encounter rate. No other procedure codes or usual and customary fees may be used.

Covered services not included in the rural health encounter

Bill the following services to MAA using your MAA-assigned provider number for that service. MAA reimburses these services on a fee-for-service basis.

The established **encounter rate** does not include the following:

- Ambulance services;
- Dental services;
- Durable medical equipment;
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;
- Family Planning services;
- Clinical diagnostic laboratory services (including the 6 required laboratory tests for RHC certification);
- Maternity Case Management services;
- Maternity Support services;
- Pneumococcal and influenza vaccines;
- Prenatal care and deliveries;
- Prosthetic and orthotic devices;
- Screening mammography services;
- Services provided in skilled nursing facility;
- Services provided to hospital patients by RHC practitioners including emergency room services; and
- X-ray service (technical component).

☞ **Note:** Interpretation (professional component – diagnostic tests such as x-rays and EKGs) is included in the RHC encounter rate.

☞ **Note:** You must contact MAA's Provider Enrollment Unit to obtain separate provider numbers to bill for these services.

What must I keep in the client's file? [Refer to WAC 388-502-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Dental photographs/teeth models;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, for six years from the date of service or longer if required specifically by federal or state law or regulation.

A provider may contact MAA with questions regarding its programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern DSHS's programs. [WAC 388-502-0020(2)]

Client Eligibility

Who is eligible?

To be eligible for services in a Rural Health Clinic (RHC), a client must present a Medical Assistance IDentification (MAID) card with one of the following identifiers:

Medical Program Identifier	Medical Program Name
CNP	Categorically Needy Program
CNP Children's Health	Children's Health Program
CNP - CHIP	Children's Health Insurance Program
CNP Emergency Medical Only	CNP - Emergency Medical Only
Detox Only	Detox
GA-U No Out of State Care	General Assistance - Unemployable
General Assistance No Out of State Care	ADATSA, ADATSA Medical Only
LCP-MNP	Limited Casualty Program - Medically Needy Program
QMB – Medicare Only	Qualified Medicare Beneficiary - Medicare Only

Are clients enrolled in a managed care plan eligible for services in an RHC?

Yes! Clients with an identifier in the HMO column on their MAID cards are enrolled in one of MAA's managed care plans. Clients **must** have all nonemergent services arranged for or provided by their Primary Care Providers (PCPs). Clients can contact their plans by calling the telephone number listed on their MAID cards.

☞ **Note:** If you treat a Healthy Options client and you are not the client's Primary Care Provider (PCP), or the client was not referred to you by the PCP, you may not receive payment. You will need to contact the PCP to get a referral. You may also need to get authorization from the plan for the service that you are providing, especially if you are not contracted as a provider with that plan. Call the managed care plan to discuss payment before you provide services.

Primary Care Case Manager/Management

For the client who has chosen to obtain care with a PCCM, the identifier in the HMO column will be "PCCM." These clients must obtain their services through the PCCM. The PCCM is responsible for coordination of care just like the PCP would be in a plan setting.

Billing

RHC services provided to MAA clients must be billed on a HCFA-1500 claim form.

What is the time limit for billing? [Refer to WAC 388-502-0150]

- Providers must submit initial claims and adjust prior claims in a timely manner. MAA has two timelines standards: 1) for initial claims; and 2) for resubmitted claims.

- The provider must submit claims as described in MAA's billing instructions.

- Providers must submit their claim to MAA and have an Internal Control Number (ICN) assigned by MAA within 365 days from any of the following:

  - ✓ The date the provider furnishes the service to the eligible client;
  - ✓ The date a final fair hearing decision is entered that impacts the particular claim;
  - ✓ The date a court orders MAA to cover the services; or
  - ✓ The date DSHS certifies a client eligible under delayed[1] certification criteria.

> ☞ **Note:** If MAA has recouped a plan's premium, causing the provider to bill MAA, the billing time limit is 365 days from the date of recoupment by the plan.

- MAA may grant exceptions to the 365 day time limit for submitting **initial claims** when billing delays are caused by either of the following:

  - ✓ DSHS certification of a client for a retroactive[2] period; or
  - ✓ The provider proves to MAA's satisfaction that there are other extenuating circumstances.

[1] **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

[2] **Retroactive Certification -** According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

- MAA requires providers to bill third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

- Providers may **resubmit, modify, or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  ☞ **Note:** MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

How do I bill for services provided to PCCM clients?

When billing for services provided to PCCM clients:

- Enter the referring physician or Primary Care Case Manager (PCCM) name in field 17 on the HCFA-1500 claim form; and

- Enter the seven-digit identification number of the PCCM who referred the client for the service(s). If the client is enrolled with a PCCM and the PCCM referral number is not in field 17a when you bill MAA, the claim will be denied.

Note: Newborns of Healthy Options clients that are connected with a PCCM are fee-for-service until a PCCM has been chosen. All services should be billed to MAA.

How do I bill for clients eligible for Medicare and Medical Assistance?

When a client is eligible for both Medicare and Medical Assistance and the services are covered by Medicare **you must <u>first</u> submit a claim to Medicare and accept assignment within Medicare's time limitations**. MAA may make an additional payment after Medicare reimburses you.

- If Medicare pays the claim, the provider must bill MAA within six months of the date Medicare processes the claims. A Medicare Remittance Notice or EOMB must be attached to each claim.
- If Medicare denies payment of the claim, MAA requires the provider to meet MAA's initial 365-day requirement for submitting initial claims. **Medicare/Medicaid crossover claims must be billed on a UB-92 claim form.**

QMB (Qualified Medicare Beneficiaries) Program Limitations:

QMB with CNP or MNP (Qualified Medicare Beneficiaries with Categorically Needy Program or Medically Needy Program)

(Clients who have CNP or MNP identifiers on their MAID card in addition to QMB)

- If Medicare **<u>and</u>** Medicaid cover the service, MAA pays only the Medicare deductible and/or coinsurance up to Medicare or MAA's allowed amount, whichever is less.
- If only Medicare **<u>and not Medicaid</u>** covers the service, MAA pays only the deductible and/or coinsurance up to Medicare's allowed amount.
- If only Medicaid **<u>and not Medicare</u>** covers the service and the service is covered under the CNP or MNP program, MAA reimburses for the service.

QMB-Medicare Only

- If Medicare **and** Medicaid cover the service, MAA pays only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less.
- If only Medicare **<u>and not Medicaid</u>** covers the service, MAA pays only the deductible and/or coinsurance up to Medicare's allowed amount.

For QMB-Medicare Only:
If **Medicare does not** cover the service,
MAA does not reimburse the service.

Third party liability

You must bill the insurance carrier(s) indicated on the client's MAID card. An insurance carrier's time limit for claim submissions may be different than MAA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you haven't received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA *Remittance and Status Report* for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA; and
- Attach the insurance carrier's statement.

If you are rebilling, also attach a copy of the MAA *Remittance and Status Report* showing the previous denial.

If you are rebilling electronically, list the Internal Control Number (ICN) of the previous denial in the **Comments** field of the Electronic Media Claim (EMC).

Third-party carrier codes are available via the Internet at http://maa.dshs.wa.gov or by calling the Coordination of Benefits Section at 1-800-562-6136.

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

Important!

Guidelines/Instructions:

- **Use only the original preprinted red and white HCFA-1500 claim forms** (version 12/90 or later, preferably on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner cannot read black and white (copied, carbon, or laser-printer generated) HCFA-1500 claim forms.

  If you need preprinted red and white HCFA-1500 claim forms, **call 1-800-562-6188.**

- **Do not use red ink pens (use black ink for the circled "XO" on crossover claims), highlighters, "post-it notes," or stickers** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, "REBILL," "TRACER," or "SECOND SUBMISSION" on claim form.

- **Use standard typewritten fonts** that are 10 c.p.i (characters per inch).
  Do not mix character fonts on the same claim form. Do not use italics or script.

- **Use upper case** (capital letters) for all alpha characters.

- **Use black** printer ribbon, ink-jet, or laser printer cartridges. **Make sure ink is not faded or too light!**

- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.

- **Place only six detail lines on each claim form**. MAA does not accept "continued" claim forms. If more than six detail lines are needed, use additional claim forms.

- **Show the total amount for each claim form separately**. Do not indicate the entire total (for all claims) on the last claim form; **total each claim form**.

Field Description/Instructions for Completion

1a. **Insured's I.D. No.**: Required. Enter the MAA alphanumeric Patient (client) Identification Code (PIC) exactly as shown on the client's monthly DSHS Medical Identification (ID) card. The PIC consists of the client's:

a) First and middle initials (a dash [-] *must* be used if the middle initial is not available).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
d) An alpha or numeric character (tiebreaker).

For example:
1. Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
2. John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the MAA client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2*.).

9. **Other Insured's Name**: When applicable, show the last name, first name, and middle initial of the insured if it is *different from* the name shown in *field 4*. Otherwise, enter the word *Same*.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.
9b. Enter the other insured's date of birth.
9c. Enter the other insured's employer's name or school name.
9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, HO or Healthy Options First Steps, and Medicare, etc., are inappropriate entries for this field.

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: When applicable. This information applies to the insured person listed in *field 4.* Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and MAA pays as payer of last resort.

11a. **Insured's Date of Birth**: When applicable, enter the insured's birthdate, if different from *field 3.*

11b. **Employer's Name or School Name**: When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being resubmitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.)

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form. You must total each page separately.**

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using a 6-digit or 8-digit date of service. (Example: July 4, 2001 = 070401 or 07042001)

Do not use slashes, dashes or hyphens to separate month, day year.

24B. **Place of Service**: Required. Enter a **3** for the Place of Service.

24C. **Type of Service**: Required. Enter a **3** for all services billed.

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate encounter code.

24E. **Diagnosis Code**: Required. Enter the appropriate ICD-9-CM diagnosis code.

24F. **$ Charges**: Required. Enter your encounter rate for the service performed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.

24G. **Days or Units**: Required. Enter the correct number of units. Use only whole numbers, not fractions.

25. **Federal Tax ID Number: Leave this field blank.**

26. **Your Patient's Account No**.: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

28. **Total Charge**: Required. Enter the total amount of billed charges. Do not use a dollar sign or decimal point.

29. **Amount Paid**: If you receive an insurance payment or client paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use a dollar sign or decimal point or put Medicare payment here.

30. **Balance Due**: Required. Enter dollar amount owing (equal to field 28 value minus field 29 value). Do not use a dollar sign or decimal point.

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**: Required. Put your *Name, Address,* and *Telephone #* on all claim forms.

GRP#: **Enter the DSHS provider number assigned to you by MAA.**

Sample:
HCFA-1500 Claim Form

(See separate file)

How to Complete the UB-92 Medicare Part B/ Medicaid Crossover Claim Form

Use the UB-92 claim form and these instructions when submitting hospital-based and nonhospital-based claims for dual-eligible [Medicare/Medicaid] clients.

Submit the UB-92 claim form along with a copy of your Explanation of Medicare Benefits (EOMB) to:

Division of Program Support
PO Box 9245
Olympia WA 98507-9245

You may not bill multiple spans of service of one claim. The information you give on the claim must match the attached EOMB or Remittance Notice. Be sure to bill MAA within six months of the statement date that appears on the Medicare EOMB or Remittance Notice.

The numbered boxes on the claim form are referred to as ***form locators***. *Only form locators that pertain to MAA are addressed here.*

Complete the UB-92 claim form in the usual manner required by MAA; however, there are form locators that need specific information indicated in order to process your claim. See the following instructions and claim form samples.

FORM LOCATOR, NAME AND INSTRUCTION FOR COMPLETION

1. **Provider Name, Address & Telephone Number** - Enter the provider name, address, and telephone number as filed with the MAA Division of Program Services (DPS).

3. **Patient Control No**. - This is a twenty-digit alphanumeric entry **that you may use as your internal reference number**. You create this number. Once you have submitted this account number to MAA, it will appear on the Remittance and Status Report under the column titled *Patient Account Number*.

4. **Type of Bill** - Enter **131** to indicate the type of bill.

6. **Statement Covers Period** - Enter the beginning and ending dates of service for the period covered by this bill.

12. **Patient Name** - Enter the client's last name, first name, and middle initial as shown on the client's Medical ID card.

13. **Patient's Address** - Enter the client's address.

14. **Patient's Birthdate** - Enter the client's birthdate.

15. **Patient's Sex** - Enter the client's sex.

VALUE CODES: Enter the following from your EOMB:

39A: **Deductible**: Enter the code *A1*, and the deductible as reported on your EOMB.

39D: **ENC Rate**: Enter the rural health encounter reimbursement as reported on your EOMB.

40A: **Coinsurance**: Enter the code *A2*, and the coinsurance as reported on your EOMB.

40D: **Encounter Units**: Enter the units of rural health encounters, as reported on EOMB.

41A: **Medicare Payment**: Enter the payment by Medicare as reported on your EOMB.

41D: **Medicare's Process Date**: Enter the date that Medicare processed the claim, as reported on your EOMB in numerals only (*MMDDYY*).

42. **Revenue Code** - Enter **001** on line 1.

43. **Procedure Description** - Enter **Total** on line 1.

47. **Total Charges** - Enter the total charges billed to Medicare, as reported on your EOMB, on line 1.

50. **Payer Identification: A/B/C** - Enter if all health insurance benefits are available.

50A: Enter **Medicare** and the carriers name.
50B: Enter **Medicaid.**
50C: Enter the name of any *insurance* that has or will pay on this claim.

51. **Provider Number** -

51B: Enter your Medicaid provider number.

54. **Prior Payments: A/B/C**

54C: Enter the total amount of non-Medicare/Medicaid payments that have or will be made.

Due from Patient: Enter the Medicaid spenddown, if any, in this box.

58. **Insured's Name: A/B/C** – Enter the last name, first name, and middle initial of the Medicaid client.

60. **Cert-SSN-HIC-ID No.** - Enter the Medicaid Patient (client) Identification Code (PIC) -an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the DSHS Medical ID card. This information is obtained from the client's current monthly DSHS Medical ID card and consists of the client's:

a. First and middle initials (or a dash [-] *must* be used if the middle initial is not available).
b. Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c. First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
d. An alpha or numeric character (tiebreaker).

67. **Principal Diagnosis Code** - Enter the ICD-9-CM diagnosis code describing the principal diagnosis.

Sample Medicare XOver

Not available to be viewed electronically.
Please call 1-800-562-6188 to request a hard copy of this billing instruction
or
Write to:

Medical Assistance Administration
Provider Relations Unit
PO Box 45562
Olympia, WA 98504-5562